HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV* Related Information

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

I consent to disclosure of (please check all that apply):

- [ ] My HIV-related information
- [ ] Both (non-HIV medical and HIV-related information)
- [ ] My non-HIV medical information **

Information in the box below must be completed.

Name and address of facility/person disclosing HIV-related and/or medical information:

_____
_____

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):

_____
_____

Relationship to person whose information will be released:_____

_____

Describe information to be released:_____

Reason for release of information: _____

Time Period During Which Release of Information is Authorized   From: _____   To: _____

Disclosures cannot be revoked, once authorized. Additional exceptions to the right to revoke consent, if any:

_____
_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligiblity for benefits (Note: Federal privacy regulations may restrict some consequences):

_____
_____

All facilities/persons listed on pages 1,2 (and 3 if used) of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize.

Signature _____   Date_____

*Human Immunodeficiency Virus that causes AIDS

** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

**Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 1:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

Name and address of facility/person to be given general medical and/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 1:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2493 or the New York City Commission of Human Rights at **(212) 306-5070.** These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature _____   Date _____
          (Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number_____

**Complete information for each facility/person to be given general medical information and/or HIV-related information.
Attach additional sheets as necessary. Blank lines may be crossed out prior to signing.**

Name and address of facility/person to be given general medical and/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 1:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

Name and address of facility/person to be given general medical and/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 1:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

Name and address of facility/person to be given general medical and/or HIV-related information:

_____
_____
_____

Reason for release, if other than stated on page 1:

_____
_____

If information to be disclosed to this facility/person is limited, please specify:

_____
_____

If any/all of this page is completed, please sign below:

Signature _____ Date_____